



Outpatient Services • Clinics and Hospitals

October 2005 • Bulletin 372

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2005 CPT-4/HCPSCS Codes and Modifiers Update

Effective November 1, 2005, the following code and modifier conversions are taking place due to annual HCPSCS updates and/or mandated HIPAA conversions:

- Conversion to the 2005 CPT-4 and HCPSCS Level II codes
- Policy updates related to the 2005 CPT-4 and HCPSCS Level II code updates
- ICD-9 procedure code update for inpatient providers
- HIPAA-mandated conversion of hearing aid and accessory codes and modifiers
- HIPAA-mandated conversion of interim modifiers
- HIPAA-mandated conversion of respiratory care practitioner codes

Policy for all updates were announced in the September 2005 *Medi-Cal Update*. Provider manual updates are included in this month's *Medi-Cal Update*.

Human Papillomavirus DNA or RNA Test Restrictions Update

Effective for dates of service on or after November 15, 2005, new reimbursement requirements will be initiated for Human Papillomavirus (HPV) test code 87621 (infectious agent detection by nucleic acid [DNA or RNA]; papillomavirus, human, amplified probe technique). Reimbursement of HPV screening is supported for women who qualify to receive the following services:

Follow-up of Low-grade Squamous Intraepithelial (LSIL) cytology result in women less than 21 years of age (HPV DNA testing at 12 months in lieu of cytology at six and 12 months is an option).

Follow-up post colposcopy in women with Paps read as Atypical Squamous Cell, High Grade (ASC-H), LSIL, or HPV DNA positive Atypical Squamous Cells of Undetermined Significance (ASC-US) in whom Cervical Intraepithelial Neoplasia (CIN) is not identified at colposcopy (may be followed up at 12 months with HPV DNA testing in lieu of cytology at six and 12 months).

- Follow-up of women with biopsy proven CIN I (HPV DNA testing at 12 months in lieu of cytology at six and 12 months is an option).
- Follow-up in women post treatment of CIN II and III (HPV DNA testing at least six months after treatment in lieu of three follow-up Pap smears is an option).

Please see Papillomavirus, page 2

Papillomavirus (continued)

Code 87621 may be billed with modifier -26, -TC or -ZS and is reimbursable once every 12 months, any provider for female recipients 15 years of age or older when billed with one of the following ICD-9 codes:

| <u>ICD-9 Code</u> | <u>Description</u> |
|-------------------|---|
| 233.1 | Carcinoma in situ of breast and denitourinary system; cervix uteri |
| 622.11 | Dysplasia of cervix (uteri); mild dysplasia of cervix |
| 622.12 | Dysplasia of cervix (uteri); moderate dysplasia of cervix |
| 795.01 | Papanicolaou smear of cervix with atypical squamous cells of undetermined significance (ASC-US) |
| 795.02 | Papanicolaou smear of cervix with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H) |
| 795.03 | Papanicolaou smear of cervix with low grade squamous intraepithelial lesion (LGSIL) |
| 795.05 | Cervical high risk human papillomavirus (HPV) DNA test positive |

Non-Benefit Codes 87620 and 87622

HPV test codes 87620 (infectious agent detection by nucleic acid [DNA or RNA]; papillomavirus, human, direct probe technique) and 87622 (...papillomavirus, human, quantification) will be non-benefits, effective for dates of service on or after November 1, 2005.

The updated information is reflected on manual replacement pages path micro 2 and 3 (Part 2), rates max lab 7 (Part 2) and tar and non cd8 1 (Part 2).

'Open Staff Privileges' Revised

Welfare and Institutions Code (W & I Code) Section 14087.28 prohibits hospitals which participate in the Medi-Cal Selective Provider Contracting Program from denying medical staff membership or clinical privileges on any qualifications other than established professional and ethical criteria, applied uniformly to all staff applicants and members. Recent W & I Code changes revised the meaning of "open staff privileges."

Section 35 of Chapter 788, Statutes of 2004 amended the code to read:

- Section 14087.28(a). A hospital contracting with the Medi-Cal program pursuant to this chapter shall not deny medical staff membership or clinical privileges for reasons other than a physician's individual qualifications as determined by professional and ethical criteria, uniformly applied to all medical staff applicants and members. Determination of medical staff membership or clinical privileges shall not be made upon the basis of any of the following:
 - (1) The existence of a contract with the hospital or with others.
 - (2) Membership in, or affiliation with, any society, medical group, or teaching facility or upon the basis of any criteria lacking professional justification, such as any basis listed in subdivision (a) of Section 12940 of the *Government Code*, as those bases are defined in Sections 12926 and 12926.1 of the *Government Code*, except as otherwise provided in Section 12940 of the *Government Code*.
- Section 14087.28(b). The special negotiator may authorize a contracting hospital to impose reasonable limitations on the granting of medical staff membership or clinical privileges to permit an exclusive contract for the provision of pathology, radiology, and anesthesiology services, except for consulting services requested by the admitting physician.

This information is reflected on manual replacement page cont ip 17 (Part 2).

ICD-9 Codes Added for Inpatient Liver and Bone Marrow Transplants

Effective for dates of services on or after November 1, 2005, the following ICD-9 procedure codes may justify enhanced hospital contract rates for transplant services.

| <u>ICD-9 Code</u> | <u>Description</u> |
|-------------------|---|
| 41.04 | Autologous hematopoietic stem cell transplant without purging |
| 41.05 | Allogenic hematopoietic stem cell transplant without purging |
| 41.07 | Autologous hematopoietic stem cell transplant with purging |
| 41.08 | Allogenic hematopoietic stem cell transplant with purging |
| 50.51 | Auxiliary liver transplant |

The updated information is reflected on manual replacement page transplant 5, (Part 2).

Use of Modifier -AG Reminder for Surgical Procedures

Providers are reminded that current Medi-Cal policy states that for multiple procedures performed at the same operative session, providers should identify the major procedure with modifier -AG, and identify the secondary, additional or lesser procedures by adding modifier -51 to the secondary procedure codes. The procedure code identified with modifier -AG is paid at 100 percent of the Medi-Cal reimbursement rate. The procedure code(s) identified with modifier -51 will generally be paid at 50 percent of the Medi-Cal reimbursement rate.

New Computed Tomographic Angiography Benefit

Effective for dates of service on or after November 1, 2005, Medi-Cal will reimburse CPT-4 code 71275 (computed tomographic angiography, chest, without contrast).

The updated information is reflected on manual replacement pages radi dia 1 (Part 2) and tar and non cd7 1 (Part 2).

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Remove and replace: anest 3/4 *, 11/12 *, 17/18 *
appeal form 1/2 **, 7/8 **
blood 7/8 *
cal child ser 7/8 *
children 1 thru 4 **
cif sp op 3 thru 8 *
cont ip 1/2 **, 5/6 **, 17/18 *
eval 11/12 *
hcpcs ii 1/2 *
hcpcs iii 3/4 *
hyst 3/4 *
inject 7/8 **, 19 thru 22, 53 *
inject list 1/2 *, 5/6 *, 9/10 *, 15/16 *, 19 *
inject vacc 1 *
mcs manag 1/2 **
medi cr op 1 thru 4 *, 9 thru 14 *
medi cr op ex 1 thru 10 *
medi non cpt 1 *
medi non hcp 1/2 *
medne 7/8 *
medne neu 3/4 *

Remove: medne non 1 thru 3
Insert: medne non 1 thru 4 * (new)

Remove and replace: modif 1/2 *
modif app 1 thru 7 *
modif op 1/2 *
modif used 3 thru 6 *
non ph 1/2 **, 7/8 **, 11 thru 15 **
non ph ub 1 thru 3 *
ophthal 15/16 *
path bil 3 thru 9 *
path chem 1/2 *
path cyto 1/2 *
path hema 3/4 *

Remove: path micro 1 thru 5
Insert: path micro 1 thru 6 (new)

Remove and replace: path organ 7/8 *
podi ub 1 thru 4 *
preg com 9/10 *
preg com exu 1 thru 4 *

* Pages updated due to ongoing provider manual revisions.

** Pages updated due to ongoing provider manual revisions. County Medical Services Program (CMSP) providers should remove these pages but retain them in the Appendix of their provider manual for future reference.

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Remove and replace: preg early 5 thru 8 *
 preg ex ub 1 thru 4 *, 11 thru 16 *
 preg glo 3 *
 psych 5/6 **
 radi 1 thru 4 *
 radi dia 1/2, 21 thru 24 *
 radi dia ult 1/2 **
 radi nuc 3 *
 rates max lab 1 thru 8
 respir 3 thru 6 *
 rural 3/4 **
 spec 5/6 **
 ster 19/20 *
 sub acut lev 3/4 **
 supp drug 3 *

Insert: surg aud 3 * (new)

Remove and replace: surg bil mod 1 thru 6 *
 surg bill ub 1 thru 10 *, 13 thru 17 *
 surg cardio 1/2 *
 surg digest 1/2 *
 surg female 1/2 *
 surg integ 3/4 *

Remove: surg muscu 3 thru 4
Insert: surg muscu 3 thru 5 * (new)

Remove and replace: surg nerv 1 thru 4, 7/8 *
 surg urin 1/2 **, 5 *
 tar and non cd1 5 *
 tar and non cd2 9/10 *
 tar and non cd3 3 thru 6 *
 tar and non cd4 3 thru 7 *
 tar and non cd5 1/2, 7/8 *
 tar and non cd6 1 thru 4 *
 tar and non cd7 1 thru 3
 tar and non cd8 1/2
 tar and non cd9 1 thru 7 *
 tar field 1/2 **
 transplant 5/6, 9/10 **
 ub comp op 25/26 *
 vaccine 3/4 *

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